ASTHMA EMERGENCY CARE PLAN 2013-2014 SCHOOL YEAR
GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION

Student's Name: _____ Date of Birth: _____

Student's Address: _____

EMERGENCY CONTACTS

Name	Relationship	Telephone	Email
1.			
2.			
3.			

TO BE COMPLETED BY THE PHYSICIAN

Please list daily controller medications this student takes:

1. _____
2. _____

Steps to take during asthma attack:

1. Give the following rescue medication (Form 5330F1 must also be completed for school personnel to administer this medication):

   _____
   Medication Name Dosage Instructions
   Should the student use a spacer with this inhaler? _____ (yes or no)

2. Have the student return to class if _____
3. Contact parent if _____
4. May repeat above dose in _____ minutes if student has no improvement in symptoms, but contact parent.
5. Call 911 if the student has any of the following:
   a. No improvement after 15-20 minutes after initial treatment
   b. Chest and neck pulled in with breathing
   c. Any respiratory distress
   d. Stops playing and can't start activity again
   e. Student is hunched over, has trouble walking or talking
   f. Lips and/or fingernails are gray or blue
   g. Other:
      _____
      _____

☐ Student should use this inhaler 15 minutes prior to physical activity (Form 5330F1 must also be completed for school personnel to administer this medication).

(-OVER-)

This student □ Should □ Should Not carry their own inhaler and use as directed. They have been instructed by me, the physician, on how and when to administer this medication. I advise that in addition to carrying their inhaler, one also be stored in the clinic for use in an emergency situation.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Telephone Number: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN

In addition to the above instructions from the physician, I wish to communicate the following information to school personnel regarding my student:

_____

_____

_____

As the parent/guardian of a student with asthma, I understand it is **my** responsibility to inform bus drivers, coaches, extra-curricular sponsors, tutors, etc., of my student's condition.

If the physician has indicated that my student can carry a rescue inhaler, I authorize my student to do so. My student has been instructed on the purpose of and appropriate method and frequency of use of the prescribed medication. He/she also understands the requirement of reporting immediately to the school health assistant if relief is not obtained after one treatment. I understand that it is **strongly advised** that an extra inhaler be stored in the clinic even if my student is authorized to carry their inhaler.

I hereby give permission for the exchange of medical information between the corporation nurse, health assistant, school principal, and the physician listed above. I also give permission for clinic personnel to share this medical information with school staff as needed to help protect my student's safety and well-being.

I agree to and wish to implement this emergency care plan for my student.

Parent/Guardian's Signature: _____ Date: _____

Printed Name: _____

To Be Completed by School Personnel

Date ECP received by clinic personnel: _____

□ ECP Reviewed by Health Assistant _____

□ ECP Reviewed by Corporation Nurse _____